FILED JUN 19 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

'57 021395 STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2651

1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
a. COUNTY Jackson			a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City	Inside Limits Yes X No ☐		c. CITY OR TOWN 3708 Kansas City	Inside Limits Yes X No ☐	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ~~4141~~ 4151 Mercier	Length of stay in lb 41 Yrs.		d. STREET ADDRESS (If outside, give location) 4151 Mercier	Reside on Farm Yes ☐ No ☐	

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Amanda		Swanson	June	3,	1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White		Nov. 5, 1868	88		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Sweden	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Swen John Anderson	Carolyn Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	None	Mable Swanson, 4151 Mercier, K. C. Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Hemorahage — INTERVAL BETWEEN ONSET AND DEATH: 7 Days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Chronic Nephritis
Chronic Hypertenson Terminal Uremia — 3 days

DUE TO (c) 331 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Arthritis

19. WAS AUTOPSY PERFORMED? 0 YES ☐ NO ☐

20a. ACCIDENT	SUICIDE	HOMICIDE	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
☐	☐	☐	

20c. TIME OF INJURY: Hour a. m. p. m. / Month, Day, Year

20d. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1917 6-3 to 1957 and last saw her alive on 6-3-57

Death occurred at ____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
J. W. Hallberg, M.D.	4620 Michigan Pkwy	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Removal	6-6-57	Rose Hill Cem.	Peace City Kans.

24. FUNERAL DIRECTOR ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Gates Funeral Home, K. C. Ks.	6-5-57	Neva Minahall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.